Part 3: Additional Medicaid Information

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Section 3.1: Hoosier Healthwise

Hoosier Healthwise is Indiana's health care program for low income families, pregnant women, and children. Based on family income, children up to age 19 may be eligible for coverage. The program covers medical care like doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning at little or no cost to the member or the member's family.

Parents and children receiving Temporary Assistance for Needy Families (TANF) as well as non-TANF pregnant women and children with incomes at or just above the poverty level may choose to participate in Hoosier Healthwise. The program covers medical care like doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries, and family planning at little or no cost to the member or the member's family.

Medicaid recipients are **not** allowed to enroll in both the HCBS Waiver Program and Hoosier Healthwise. They must choose one program or the other.

Additional information about Hoosier Healthwise may be found at http://member.indianamedicaid.com/programs--benefits/medicaid-programs/hoosier-healthwise.aspx

Section 3.2: Care Select

Care Select is a health care program that is designed to serve Medicaid recipients who may have special health needs or benefit from specialized attention. In *Care Select*, you pick a primary doctor and a health plan by choosing one of the Care Management Organizations (CMOs) contracted with the state to coordinate your health care needs. The CMO will assist you in coordinating your health care benefits and tailor them to your individual needs, circumstances and preferences.

People served by *Care Select* may be aged, blind, disabled, wards of the court and foster children, or children receiving adoptive services. You must also have one of the following medical conditions:

- Asthma
- Diabetes
- Heart Failure
- Congestive Heart Failure
- Hypertensive Heart Disease
- Hypertensive Kidney Disease
- Rheumatic Heart Illness
- Severe Mental Illness

- Serious Emotional Disturbance (SED) for Wards and Fosters
- Depression

Care Select is an optional program for those who qualify. If you think you should be in this program, discuss it with your doctor. Your doctor can request that you be added to this program if you have a qualifying disease and meet all other criteria. If you qualify for *Care Select*, but do not wish to be on *Care Select*, you may choose to be on Traditional Medicaid.

Home and Community Based Services (HCBS) waiver recipients are **not** eligible for the *Care Select* program, even if you have one of the included chronic conditions. HCBS waiver recipients are eligible for case management under the waiver, which is similar to disease management.

Additional information about *Care Select* may be found at http://member.indianamedicaid.com/programs--benefits/medicaid-programs/care-select.aspx

Section 3.3: Hospice Services

Individuals who receive Medicaid HCBS waiver services and elect to use the Indiana Health Care Program Hospice benefit do not have to terminate their waiver program. However, the hospice provider will coordinate the direct care for those services held in common by both programs, so there is no duplication of services. In short, the individual receiving waiver services, who elects the hospice benefit may still receive waiver services that are not related to the terminal condition and do not replicate hospice care. The hospice provider and the case manager must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member.

Section 3.4: Spend-down

In certain cases, a Medicaid member may have income or resources that are too high to qualify for Medicaid services; in these cases the member has what is called a spend-down. A spend-down is the amount of money a person must spend on qualified medical expenses each month before Medicaid will pay for services. After the spend-down is met each month, Medicaid will begin to cover the remaining medical expenses that you have incurred. An example of spend-down is:

Your income is $1000 monthly

The income limit for Medicaid is $700 per month.

The spend-down is the difference between the income limit ($700) and your income ($1000) equaling $300.

Therefore, you must incur $300 in medical expenses each month before Medicaid coverage will begin to pay for services. You can meet your spend-down by paying for any medical service that is covered by your Medicaid program. This could be prescription drugs or a doctor visit.

REMEMBER: This is just an example and is not indicative of what the income limits are or what your spend-down maybe if you are over the income limit. Many members do not have a spend-down at all. You will be notified of any spend-down you will have when you are notified of acceptance into Medicaid.

Section 3.5: M.E.D. Works

Introduction to M.E.D. Works

In July 2002, Indiana created a health care program called M.E.D. Works, which stands for **M**edicaid for **E**mployees with **D**isabilities. M.E.D. Works is Indiana's health care program for working people with disabilities. Now people with disabilities do not have to fear losing their health care benefits under Medicaid or having a Medicaid spend-down (spend-down is an out of pocket cost for members whose income or assets are too high) just because they get a job, get a raise, or work more hours.

M.E.D. Works would allow you to work without losing health care coverage while also being able to save money for goals like retirement, education or starting a new business. As a M.E.D. Works member you may pay a small monthly premium based on your income; however, this is much smaller than the cost of a spend-down payment.

Who Is Eligible?

To be eligible for M.E.D. Works, you must:

- be age 16-64,
- meet certain income and assets guidelines (see below),
- be disabled according to Indiana's definition of disability, and
- be working

Most M.E.D. Works members will be those already on Medicaid and are often on Social Security Disability Income (SSDI). However, new members who are working and disabled may still have M.E.D. Works as an available option. Like all Medicaid programs, qualifying is partially based on your income (money earned from a job and unearned income such as a Social Security check) and you may pay a Medicaid premium to receive coverage. The premiums are generally much lower than the Medicaid disability spend-down amount. Please note that M.E.D. Works is an individual only program. Your spouse or children will not be eligible through you for coverage under M.E.D. Works, even though they may be eligible for other Medicaid services.

Financial Eligibility

To financially qualify for M.E.D. Works, you must not have countable income above 350% of the Federal Poverty Level (FPL). The Federal Poverty Level is determined by the Federal government and changes on an annual basis. Below is a FPL table for 2012 that can be used as a guide. The only way to know for sure is to apply.

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890
For families/households with more than 8 persons, add $3,960 for each additional person.	

There are certain types of income that are not included when deciding if you are eligible for M.E.D. Works, examples of these include;

- tax refunds,
- grants or scholarships allowed by federal law,
- Impairment Related Work Expenses (IRWE's), and
- income of your spouse or parents

In addition to income, your assets are also part of your eligibility determination.

Certain assets do not count when deciding if you are eligible for M.E.D. Works, these include:

- a car (if you use it to drive to work or medical appointments),
- a home (if it is where you live),
- burial spaces,

- retirement savings held by you or, if you are married, your spouse.

Medical Eligibility

In Indiana, Medicaid has its own eligibility criterion for disability determination. This criteria differs from the Social Security Administration's eligibility determination. In Indiana, the definition of disability is a physical or mental impairment verifiable by a physician that is expected to last 12 or more months or result in death.

M.E.D. Works Services

M.E.D. Works offers the same services to its members with disabilities as those in regular Medicaid. This means if you are already a member of Medicaid because of your disability, but would like to start working your benefits under M.E.D. Works will be the same as they are now.

M.E.D. Works Savings for Independence and Self-Sufficiency

Another benefit that is available to M.E.D Works participants is called the Savings for Independence and Self Sufficiency account. It is a special account for members who have extra money to set aside to save for purchasing goods or services that increase their ability to find or retain a job and make them more independent.

Members can put up to $20,000 in the approved accounts; before the accounts are approved a member must explain what he/she will be using the money for and how it helps them to improve their employability or independence. Each request is based on an individual's unique situation and goods or services to be purchased must meet some of the criteria listed below:

- Your savings will be used to buy something that is necessary for you to keep or increase your employment.
- You must explain what will be purchased and give an expected date that you will purchase the item.
- Your goal must be something that you can achieve in a reasonable amount of time.
- Your account cannot be used for personal recreation.

If you are interested in completing an application for an Independence and Self-Sufficiency Account for M.E.D.Works members, contact your local Division of Family Resources.

Section 3.6: Medicaid Prior Authorization

CMS requires that a HCBS waiver member exhaust all services on the State Plan before utilizing HCBS waiver services. HCBS waiver programs are considered funding of last resort and have a closed funding stream.

The following list provides the hierarchy of funding streams for ease of reference with HCBS waiver programs.

1. Private Insurance/Medicare
2. Medicaid State Plan Services
3. HCBS Waiver Programs

Issue 1: As a funding stream of last resort, teams must ensure that all other revenue streams are exhausted before utilizing waiver services.

Issue 2: Medicaid Home Health Prior Authorization Requests must specify if there are other caregiving services received by the member, including, but not limited to services provided by Medicare, Medicaid waiver programs, CHOICE, vocational rehabilitation, and private insurance programs. The number of hours per day and the days per week for each service must be listed.

For additional information please visit Indiana Medicaid at http://provider.indianamedicaid.com/general-provider-services/providing-services/prior-authorization.aspx